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ABSTRACT

Persons from minority groups often are at a linguistic disadvantage in (Philadelphia, Pennsylvania, Nov. 22, 1975) the language and culture of the physician or psychoanalyst, who may be unaware of problems of understanding. Patients have certain language rights in medical care. (1) The right to human dignity in the medical relationship is jeopardized by, for example, a specialized professional vocabulary, the different cultural background of doctor and working-class patient, and the asymmetrical status of doctor and patient, where the doctor as the superior controls the conversation. During taped medical interviews with black, inner-city residents, the patients adopted their best English and tried to use medical terminology to avoid embarrassment. (2) The right to know what is wrong with their bodies involves the doctor's ability and desire to communicate and the patient's ability to understand. Even common medical terms may not be understood by ghetto residents. (3) The right to know why certain tests or treatments are given is important to the patient's peace of mind and dignity. (4) The patient's right to make decisions about alternative treatment must be maintained through clear explanation of test results and alternative treatments. It is suggested that medical schools include training in personal interviewing and minority languages and cultures and, if possible, that they recruit working-class doctors. (CHK)

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THE PATIENT'S RIGHT TO CLEAR COMMUNICATIONS IN HEALTH AND MENTAL HEALTH DELIVERY SERVICE

The language rights of people have never been given very serious consideration in this country. The melting-pot, assimilationist perspective has dominated the social and political activities of leaders almost from the very beginning. It is well a known fact that immigrants were obliged either to take jobs in which communication problems were minimized (as in labor) or to learn the language of the majority, thereby to improve their chances of upward mobility.

Sociolinguists, perhaps more than other scholars, have been faced with the fact that users of language are not really very aware of the vehicle by which they communicate their ideas, desires, commands, etc. Thus most people are surprised by the way they sound on audio-tape, and they are almost always chagrined by the way they appear to communicate on video. They are relatively unaware of how they reveal such things about themselves as where they come from, what education level they have achieved, their attitudes toward their topic, their listeners and themselves and many other things. Recent

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research on language variability has revealed a wealth of information about the linguistic characteristics of vernacular Black English,[1] as well as the English of American Indians,[2] Mexican Americans,[3] Puerto Rican Americans,[4] and Appalachians.[5] In addition, a recent focus of interest on sex differences in the use of language has been revealing.[6] What has been lacking in all of this research is the study of the effects of institutions on the speech of individuals and the influence which these effects have on the problems of language users.[7] For example, sociolinguists have recently become concerned about how teachers learn how to talk like teachers and how this affects their communication with students. They are also studying how students learn how to talk like students and how this speech reflects their roles in learning. One might easily argue that students, by nature of their role in the learning process, have a right to clear communication on the part of the teacher. This is often assumed to be the case but, in actuality, little is done to assist such clarity, particularly when it is cross cultural in nature.

As things now stand, the typical patient from a minority group is in a similar position to that of the minority student in the schools. Much has been said about compensatory

education in recent years. What compensatory education means is that the institution (the school) does not feel that certain minority group children are culturally, socially or linguistically ready for education. To make them ready, a program is devised that will change their culture, their social behavior and their language to conform to the expectations of the school. Compensatory education argues essentially that the child must be like the school in order for the school to be able to teach him. Current medical practice utilizes a similar communications mode. The patient must adjust to the language and culture of the physician or psychoanalyst. The medical profession does no better job of starting with the patient where he is than does the teaching profession. A great deal of doctor-patient miscommunication is currently taking place not simply because of the emotionally charged nature of the interaction and not simply because of the doctor's inconsiderate use of medical jargon, but because of a critical lack of awareness concerning the linguistic and cultural systems which some patients bring with them to their first meeting with the person to whom they entrust their health.

This paper will investigate the language rights of patients, particularly those patients whose rights are most violated because of their education, poverty, sex or ethnicity.

Thanks to a new sense of consumers' rights, to minority awareness, to the Women's Liberation Movement and other modern developments, people are beginning to awaken to their rights. In the area of law, for example, recent strides are being made in some areas. In some states, police are required to state the charges, at least, in the language of the apprehended person. On the other hand, many language rights are still being overlooked. For example, the case of the judge's instructions to the jury just before it is sent out for deliberation is currently under investigation.[8] Common jury instructions have been shown to be almost totally incomprehensible, yet the balance of justice rests on the judge's ability to explain to the jurors exactly what they must consider when weighing the evidence.

Insurance companies are even beginning to recognize the rights of customers to understand what their coverage limits really are. Both Sentry Life Insurance and Nationwide Mutual Insurance Company now offer plain talk automobile insurance policies throughout the United States. The Sentry auto insurance policy compares to the older version as follows:

Older Version	Newer Version
If the company revises this policy form with respect to policy provisions, endorsements or rules by which the insurance hereunder could be extended or broadened without additional premium charges, such insurance as is afforded hereunder shall be so extended or broadened effective immediately upon approval or acceptance of such revision during the policy period by the appropriate insurance supervisory authority.	We'll automatically give you the benefits of any extension or broadening of this policy if the change doesn't require additional premiums.

This new sense of the rights of consumers, minorities, and the oppressed leads to the development of at least four major rights of patients:

1. The right to human dignity in the medical relationship.
2. The right to know what is wrong with their bodies.
3. The right to know why certain tests or treatments are being made and what such things are supposed to reveal.
4. The right to make decisions about the treatment alternatives available to them.

The remainder of this paper will treat each of these rights individually, noting past communication failures which violate these rights and suggesting communication structures available

for favoring them. Examples will be provided from some hundred tape recorded medical interviews, most of which were recently conducted at the Georgetown University Outpatient Department as part of our ongoing research into doctor-patient communication.[9]

The Right to Human Dignity in the Medical Relationship

Much has been said about the indignity of a woman's visit to the gynecologist. Evelyn S. Gendel calls it the feeling "... of humiliation at having to greet a physician you hardly knew while flat on your back, your feet in stirrups, your nude body swathed in a sheet."[10] Although it is hard to imagine a more vivid potential violation of the patient's rights as a human being, almost everyone faces such indignity in the medical interview. For example, the patient is often ushered into an empty examination room containing one stool, one small desk, a straight chair and an examination table. An immediate problem must be faced. Where does one sit? If you lie on the table, it may seem presumptuous or premature. If you sit at the desk, you may be usurping the physician's work area. If you sit on the stool, you may be invading the doctor's private territory. No matter what you do, you run the risk of being wrong.

Once the seating dilemma is solved, a myriad of other potential indignities remain. The conversational rules of the medical interview work heavily against any semblance of patient dignity. Recent research in conversational analysis focuses on openings, the recurrence of speaker changes, gaps, overlaps, turn taking, repair mechanisms and closings. Doctor-patient communication is substantially different from ordinary conversation in almost all of these points, largely because of the inherent status differences between the speakers. The opening, for example, is more likely to be routinized along the following lines:

D: Hello, Mrs. Gordon, I'm Doctor Grable.

P: Hello, Doctor.

Like all conversation openers, this utterance may have several superimposed functions. It may expose the doctor's status to all future conversational behavior, but it can also make the patient feel comfortable that she has been addressed by name. A variation on this opener is one in which the asymetrical status is made even clearer:

D: Hello, Jane, I'm Doctor Grable.

P: Hello, Doctor.

In this case, the power of referencing oneself as <u>doctor</u> is heavily supplemented by referencing the patient by first

name only. This technique, incidentally, is not limited to women patients, but it most certainly has high incidence with women.

Assuming that the patient is treated with dignity during the openers, however, a great many pitfalls are yet to follow. An eager and cooperative patient, for example, runs a great risk if he volunteers more than is expected by the physician. Overhelpful suggestions are usually met with rebuff:

P: I'm here because I think I have phlebitis in my leg.

D: Everybody thinks he has phlebitis these days. Just tell me where the pain is. I'll do the diagnosing.

The communication rule which can be deduced from this encounter is that patients are to be descriptive but not to the point at which they appear to be diagnosing, in this case, playing the doctor's role. The patient's error is not substantially different from that of sitting in the wrong chair, as noted earlier.

Similarly, a second communication rule involves involves interruptive asymetry. A physician can interrupt a patient at any point, but a patient is not expected to interrupt

the doctor. This is a common principle in asymetrical social relations, noted particularly in schoolrooms where teachers can interrupt students but become irritated when students interrupt them. The role relation is clearly superior to inferior, at least as far as the communication is concerned.

Further evidence of this asymetry can be seen in the rule for handling gaps in the doctor-patient communication. Whereas in regular conversation, both participants have prescribed obligations to avoid overlong silences, in the medical interview, the doctor allows for long gaps before he takes his communication turn, and the patient rarely offers to fill this silence.

In addition, the doctor's superiority is reflected in other types of linguistic behavior. He initiates and terminates all the activities relevant to the interaction. He determines the direction, the length and the content of the interview. Lucienne Skopek has recently investigated the physician's linguistic presentation of authority along with the strategies which he uses to make the patient comfortable.[11] Three of the strategies which she categorizes are:

1. The doctor's control over the progress of the interview
2. His display of expertise

3. His paternalism

The doctor's control of the communications can be seen, for example, in his facility for switching from subject to subject without the normal communication transitions:

D: Do you wear glasses?

P: Yes.

D: O.K. Now, have you been drinking a lot of water lately?

The doctor starts things, terminates them and changes direction as he wishes. He truly has control over the communication.

The doctor displays his expertise by giving the patient approval, by offering assurance, by explaining symptoms and treatment and by showing disapproval. It is in the latter category, showing disapproval, that evidences of paternalism are most noticeable:

D: I'm a little unhappy, though, that you're starting to gain weight.

In instances such as this, the physician conveys more than professional opinion. He presupposes, in fact, that the patient will consider his happiness in her future behavior in order to prevent another disappointment. This is a clear case of paternalism.

In a recent article on doctor-patient communication problems, deBousingen and Timmons stress the futility with which many physicians and psychoanalysts try to translate bodily experience into language.[12] They cite similar examples of their own frustration in dealing with patients or relatives of patients, and point out the need for research in this area. From these and similar examples it is possible to conclude that the communication between patient and doctor begins with a tremendous handicap--that of a supercharged state of emotion which colors the patient's perception of what the doctor is trying to say. This is probably not different from other communication breakdowns which involve emotional charges as distractors.

Although emotional involvement is an important part of the potential breakdown of communication between patient and doctor, it will not be the major focus of our attention here. One aspect of this point of view is not unknown to the medical profession, having been called to the attention of doctors by C.P. Kimball in Annals of Internal Medicine,[13] C.M. Boyle in British Medical Journal[14] and P.W. Haberman in Public Health Reports.[15] Kimball, representative of such articles, observes:

> The Physician speaks a strange and often unintelligible dialect. He calls everyday common objects by absurd and antiquated terms. He speaks of mitral feed-back. This world is peopled with cirrhotics, greensticks, and hebephrencis. The professional dialect creates a communication gap between physician and patient that is generally acknowledged by neither.
>
> . . . Increased specialization refines the physician's particular dialect, and he becomes much like the computer, tolerating only the imprint of words that fit into the programmed languages.[16]

In addition to the emotional state of the patient, then, a second factor in patient-doctor communication failure comes from the specialized professional vocabulary of the physician.

A third arena of mismatch between physician and patient stems from a socio-economic reality of our culture. Medicine, as a profession, is a strictly middle-class phenomenon. Of this, Kimball points out: "Although medicine has traditionally been the most accessible of the professions in terms of providing for upward social mobility, it has recruited most of its manpower from the middle class, especially the upper middle class. These groups display life styles, thought processes, and a dialect far removed from those of most patients.[17] This situation obtains equally for psychoanalysts as Hollingshead and Redlich clearly indicated in 1958 when they pointed out that money commands attention from psychiatrists.[18] Those who are relatively poor or uneducated are given little or no attention and it has been estimated by one prominent psychoanalyst that an overwhelming majority of presumed successes in psychotherapy are with middle-class patients.[19] A suitable patient, in fact, might well be defined as one who is comfortable with the language and culture of the therapist, which is by definition, middle-class.

Various types of emotional, jargonistic and cross-cultural communication breakdowns have been found in recently reported studies or in actual observation.

In his recent description of the long and stormy series of involvements of his son with eight therapists. James Wechsler points out both the good and the bad in therapy sessions.[20] Michael Wechsler committed suicide

at age 26 and his father perceptively describes the problems of translating analytic vision into therapeutic action that works. In his review of this book, Robert Coles points out examples of all three of these contributions to patient-doctor communication failure:

> Jargon: "Psychiatric terms, apparently so clear-cut and emphatic, have extraordinarily versatile lives: They come and go, blend into one another, are used by one doctor, scorned by another." 21
> Emotion: "Mr. Wechsler also describes the social workers who say, without expression, only 'How do you feel?' or 'What are your feelings about that?' One wants, at the very least, to tell them to come off it... What Mr. Wechsler objects to and satirizes is something else--the heavy self-righteousness that the parents of a troubled child are especially apt to experience at the hands of certain 'mental health professionals...' It comes across as a mixture of rhetorical phrases, thinly veiled accusations and galling ...self-confidence."22
> Culture: ... psychiatrists make themselves available to those of a special kind of intimacy provided by the doctor-patient relationship." 23

The right to human dignity frequently violated in the health delivery system, then, stems from a number of causes such as:

1. An inconsiderate communication to the patient about certain common procedures, even to such matters as where to sit down.
2. An asymetrical communication relationship which grows out of linguistic reflections of power indicators.
3. A failure, on the patient's part, to determine the exact extent to which volunteered information will be appreciated or tolerated by the physician.
4. An inability to comprehend the appropriate interruption patterns in doctor-patient communication.

5. Problems with the tolerance of communication gaps, especially on the part of the patient.

6. A paternalistic communication on the part of physicians.

7. An emotionally charged communication situation.

8. A long tradition of medical jargon.

9. A culture gap between doctor and patient.

In addition to these causes, all of which can be found in doctor-patient communication in all walks of life, an additional burden afflicts the minority, poverty level patient. A large component of our Georgetown University Hospital Outpatient Department subjects were Black, inner-city women. Most evidenced a strong effort to produce their best, most formal English, as free as possible from linguistic features which might be stigmatized.

The patients generally guarded against the use of vernacular English by offering relatively short and formal responses, slipping only in utterances which might be considered non-medical or near social, such as:

D: Does Mr. Jones work?

P: He work manually. He work at the courthouse downtown.

or in hypercorrections such as:

P: Well, I just had infection, you know--a kidneys infection.

or in emotional circumstances such as the description of intense pain as follows:

D: And what's,what's the chest pain like?

P: They don't really stay in one place. They comes right up in here, then it goes round the side, then, you know, just up and down and round the arm.

D: Ever down your arm?

P: Yes, in this arm here and it, and like when I wake up, I can't hardly hold it, you know, it go to sleep. It's all pain here--hurts--and then when I wake up I can't hardly close my joints--so stiff.

D: Is this--does it hurt?

P: Yeah, and then I, you know, when I try to use it, it feel like it goes dead and don't have no feeling in it.

Most generally during the major portions of the medical interview, however, very little vernacular Black English was employed by the patients, despite every indication that such a vernacular is habitual in more formal contexts. This suggests that they were putting on their best English for the occasion, a fact which in itself suggests that they were attempting to speak the way doctors do.

Occasionally doctor talk was actually learned during the interview:

D: And have you ever had any accidents, breaking an arm, break a leg...?

P: Not broken, but, I, when your arm is in a sling that means it's not broken. It's not always knocked out of place, but this was when I was a child.

D: It was dislocated.

P: Well, right, dislocated, OK (nervous laughter)

Another instance of this learning can be seen when a woman who had had six previous pregnancies learned the sequence and language of routine responding very quickly:

D: OK, now your second child?

P: 1959, Georgetown, normal pregnancy.

D: And how about the, uh, duration of labor?

P: I'd say it was 1:00 when I came here that night and my son was born at 5:30 in the morning--5:30 a.m.--so I guess it must have been around 4 hours.

D: And ...

P: Normal. They were all six pound babies.

This anticipatory response continued through the descriptions of the other four deliveries as well:

D: And your fourth child?

P: 1961

D: Where was she born?

P: Here, the same, and I don't remember.

D: (Laughs) We're getting this down pat now, aren't we?

In addition to the direct teaching of medical terms (as in the case of dislocated arm) and cumulative experience (as in learning the predicted medical history question sequence [immediately preceeding]), patients also learn to talk doctor language in a rather dangerous manner as a result of intimidation:

D: You are drinking a lot of milk, aren't you?

P: Oh, yes, I drink a lot of milk.

Upon completion of the interview, we overheard the nurse ask the patient the same question and the patient answered, this time truthfully, that she

hated milk and never touched it. Why would she lie to the doctor? Probably because the question was asked in such a way that the patient was afraid to answer truthfully.

Another level of intimidation seems to derive less from the doctor's manner than from the obviousness of the question. Somehow we expect ourselves to have perfect memory for certain things like our telephone numbers, our family's birthdates and other such matters. Our data reveal several examples of patient embarrassment at such lapses in memory:

D: Now, your first child...what year was he born?

P: She was born in 1957.

D: 1957?

P: This is terrible! I have to think.

Equally embarrassing is the patient's general inability to pronounce the names of drugs properly or, in some cases, even to remember them:

D: Chest pains? OK. Do you use any medications?

P: I was on, uh, what you call it? Diagrens--they call Diagr... Diagrens, like little pink pills.

D: Hmmm. Have you ha..., have you taken them during this pregnancy?

P: No.

D: Anything that you've taken during this pregnancy?

P: I had some Dia...They gave me some vitamins, some green pills and I had some little, bitty white pills and some red pills.

This interlude was particularly tender because of the patient's complete failure at speaking doctor talk. She got no reinforcement from the doctor, who may not know what Diagren is either, and, lacking support and realizing defeat, the patient resorted to the total layman, even childish language of red, green and white pills.

In some cases, clear evidence of a patient's ability to talk doctor language seems apparent:

D: Were there any complications as far as you were concerned?

P: Well, I did have excessive weight gain as I have now and, uh, that was toward the end of the pregnancy and they put me on a salt-free diet.

This exchange came at the very end of the interview, and perhaps evidences the patient's language learning skills, even to the extent of impersonalizing her pregnancy to <u>the</u> pregnancy and sprinkling lightly with hospital lingo.

It should be apparent from the preceeding examples that the right to human dignity in the medical interview is tenuous, at best, with the minority, poverty level patient. Not only must such patients be subject to the nine normal causes of communication problems found in the communication routines of doctors and patients, but their dignity can be violated as well from such causes as:

10. the need to speak the social dialect of the doctor, a form of English in which the patient is less comfortable and less efficient.

11. The problem of not understanding or remembering the special terms or jargon of medicine.

12. The desire to please the doctor, even to the extent of lying to him, especially when intimidated.

The Right to Know What is Wrong With Their Bodies

If patients do not know what is wrong with them after communicating with their doctors, we may suspect one of several possible causes:

1. The doctor has not communicated clearly.
2. The doctor has deliberately withheld or distorted the real facts about the patient's condition.
3. The patient is at fault, himself.

Our research at Georgetown clearly demonstrates instances of the doctor's failure to communicate clearly enough for the patient to understand.

On some occasions the doctor's questions are simply not understood by the patient:

D: Have you ever had a history of cardiac arrest in your family?

P: We never had no trouble with the police.

...

D: What's your name?

P: Betty Groff.

D: How do you spell that?

P: B-E-T-T-Y.

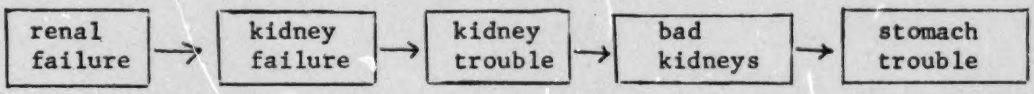
...

D: How about varicose veins?

P: Well, I have veins, but I don't know if they're close or not.

In the analysis of the taped medical histories, however, we were only infrequently given such clear examples of misunderstanding.

The problem of wording involves the translation of medical terms into everyday language. One important research question involves the difference between receptive knowledge of such terms in contrast to their productive knowledge. In probes about what a working-class patient's father died of, the term stroke may not be as likely to be understood as high blood pressure, a term in common use in the ghetto community (and in most working-class communities, regardless of race). An important research question involves the degree to which technical accuracy can be gambled for patient understanding. In some cases the chance of error will be slight (T.B., for example, is more widely understood than tuberculosis). A semantic continuum for investigation may appear to be somewhat along the following lines.



It might be pointless to expect a ghetto resident to understand renal failure but the other end of the continuum may be too vague to be helpful to the analyst. On the other hand, if stomach trouble is as sophisticated as the patient can get, we will have to learn to use this information.

Medical specialists will need to learn that, in ghetto communities, questions involving expressions such as diabetes are less likely to be understood than sugar or sugar diabetes, and heart disease is more likely to be recognized as heart trouble. In such cases as the latter, it may be true that patients can respond to the stimulus heart disease even though they use the term heart trouble.

But we do not know, as yet, if even this is true. In any case, problems involving the heart are not generally thought of as a disease in the working-class community. There are, in addition, many other medical terms used by most doctors which are at best ambiguous to ghetto patients. Consumption, for example, in Washington, D.C., is used in reference to a person who drinks himself to death. Diarrhea is more commonly known as runny bowels or running off at the bowels.

The doctor's over-use of his technical language can estrange him from the patient by setting himself on a much higher intellectual level. This may cause the patient to fear asking questions that the doctor might consider stupid or superfluous. One patient received the following typed physician's report from the clinic where she was examined:

> BARIUM ENEMA WITH AIR CONTRAST: There is normal filling evacuation of the colon. There is reflux into the terminal ileum which appears normal. There are multiple nontender diverticula, predominantly involving the descending colon and sigmoid portion of the colon. No other abnormalities are identified. Incidently noted is calcification within the uterine fibroids in the true pelvis.

This was the only information she received on her medical condition.

There is also evidence that some patients feel that important information is being kept from them - information which they have a right to know. Among other things, the National Hospital Association's recent study of doctor-patient relationships has yielded ten questions most often asked by patients. Among these questions is the following: "Why don't doctors explain a medical problem in simple language that a patient can understand?"

Heart surgeon Michael E. DeBakey replied to this question: "Most doctors don't want their patients to understand them! They prefer to keep their work a mystery. If patients don't understand what a doctor is talking about, they won't ask him questions. Then the doctor won't have to be bothered answering them."[24]

In tape recorded medical histories it is difficult to establish whether or not critical information is being withheld from patients by their physicians, but in a questionnaire survey of over a hundred patients sitting in waiting rooms at Georgetown University Hospital revealed that 70% of the patients believe this to be true. What seems particularly interesting about this figure is that it stands as the clearest position of the patients surveyed on any of the questions asked. Other questions asked whether or not they felt that their doctor understood them, whether they understood the doctor, and whether the doctor spent enough time with them. Informal discussions about the rights of patients to be told, for example, about the exact chances for their recovery or improvement after surgery, surgeons tend to be very conservative. One explained to me that if a patient really knew that his surgery had only one chance out of five of being successful he would probably never elect to have the surgery. To me, the patient's response appeared to be reasonable. If his chances are only one in five, he might well not wish to go to the trouble. In any case, he should have the right to know the truth.

Sometimes, of course, the patient is at fault for not knowing what is wrong with him. Nor do I wish to make a lop-sided case against the medical profession. Many doctors are careful and conscientious about explaining

technical matters to their patients in reasonably non-technical terms. Naturally, some doctors are more sensitive than others to their patients' lack of knowledge of doctor talk. Some attempt to determine what the layman needs to know is made:

Relative: Is he gonna live?

D: Well, are you his wife?

P: Yes.

D: Well, he's had a cardiac arrest. Do you understand what this is?

P: Yeah.

D: Well, he's in very critical condition. We have a tube in him and he has some pressure of his own. So, we'll see him in about a half-hour if there's been any change.

Sometimes the patient is not capable of understanding some aspects of his treatment. All the physician can do is try his best. But it is the right of the patient to know and to make decisions.

<u>The Right to Know Why Certain Tests or Treatment Are Being Done And What Such Things Are Supposed to Reveal</u>.

A great deal could be learned by physicians from the contrastive technique of one physician in our study whose demeanor was relaxed, congenial and enthusiastic. Some random questions from his medical histories will serve as examples:

...Here's an illustration of what I mean.

...Great! It'll probably work out fine for you.

...Let's watch that but don't worry too much about it.

...You look like a million dollars.

...Mrs. M, are there any questions I can answer for you?

...No problems here. And your last labor was much to easy.

...So what I'd like to say is that everything that's going on is quite normal.

It may take a long time for this doctor's patients to learn to take advantage of the openings he regularly provides thems to ask any questions they want. One of his patients confided:

> I thought he was too busy so I didn't ask a lot of things until I was in my ninth month. Then Dr. G realized that I, you know, had been holding back. But we got everything straightened out in time.

This same doctor evidenced a clear appreciation of the language needs of his patients. Although he never attempted to speak Vernacular Black English himself (fully realizing how ludicrous it might sound), he was sensitive to his obligation to help the patient understand <u>his</u> language, without being patronizing or stuffy. For example, to a sixteen year old patient he said:

> It might be advisable to induce forced bleeding. Incidentally, Ann, you might have noticed that you have a lot of mucus in your flow and that's normal...and it's called lucorbea.

The approach was not, "You have lucorbea." Such a statement would either require the patient to ask what the term means, thus lowering her status even further or to retreat to fearful and ignorant silence, a strategy which is frequent in our data.

Skopek has dealt with doctor's explanation to patients, dividing such activity into four categories:[25]

1. Telling the patient what he is doing.
2. Telling the patient what he is about to do.
3. Explaining symptoms.
4. Explaining treatments.

It would seem a minor thing to explain to a client what it is that you are doing for him. In most business and professional encounters, such explanation is expected by the client. Examples of this sort of activity in the medical context are as follows:

...I'm trying to find out what you think is going on exactly, what you see as the main problem.

.."I'm trying to get an idea if he might have a chronic infection."

When a physician explains to a patient what he is about to do he often softens the clinical harshness of the language probings, the frightening instruments or the invasion of privacy with what linguists are currently calling hedges.[26] Hedges serve as softeners by giving the listener options to interpret and react to what the speaker said without offending or asserting one's opinion too strongly. Some examples are as follows:

...Let me see what your lab work showed.

...Let me just ask you about general questions.

...Let me get some idea of what our home life is like.

...OK, well, I think what I'll do, I'll give you a brief exam.

...Basically, what I'd like to do quickly is just sort of go over some of the stuff...get a quick general history on you, give you a quick physical.

The goal of explaining symptoms is simply to relieve some of the patient's anxiety by clarifying the cause of her symptoms:

> ...It's very common to have cystitis when your bladder gets infected.
>
> ...I think once you get over your nerves...your appetite will come back.

By explaining the treatment the doctor displays a certain confidence in the patient by assuming that he can understand his rationale for prescribing a certain treatment and may increase the patient's motivation to cooperate. Francis reports that in a study of 800 patients in a Los Angeles clinic a major factor in non-compliance with medical advice was the failure to receive an explanation for the illness.[27] A positive example of such explanations in our study include the following.

> ...Well, I've got to explain one thing to you about taking kidney medicine, OK?

The preceeding quotations are primarily positive examples of the ways physicians can help their patients understand their treatment routines. It is difficult to cite negative examples since the absence of such communication is the crux of the problem. What is clear is that the patient has a right to such information and that successful doctor-patient communication makes it available.

The Right To Make Decisions About The Treatment Alternatives Available To Them

Although the type of research reported here does not lend itself to supporting data for this patient right, it must be stressed because it is the natural outgrowth of the preceeding patient rights. Patients should learn that they are entitled to all the test results and a clear explanation of what they mean. They should learn that they have a right to participate in the decision making about their treatment where alternatives exist. These alternatives should be explained, with pros and cons, in such a way that the patient can have some control over his own body. The rights of women patients have been much discussed in recent days and it appears, as if often the case, that the wisdom of these rights is equally applicable to everyone, but particularly to those for whom these rights have been difficult to obtain.

What Can be Done?

It is not often that research on the problems of communication between doctors and patients outlines a set of rights for patients. As is often the case, the rights of oppressed groups including minority, poverty-level patients, are most prominent for it is these people who have been least successful in obtaining treatment with human dignity, knowledge of what is wrong with them, information about why their treatment is being carried out and the clear alternatives necessary for making decisions about their own health delivery. The medical profession has been trained for years to detect and cure diseases and to recognize symptoms rather than to acknowledge the people in whose bodies these symptoms reside. There will be little effective health or mental health delivery service

if the prospective patients do not present themselves for analysis or, when they do appear, the communication fails. One way to improve this situation is to humanize the health treatment communication channel. Kimball has recommended that medical schools act to sharpen the future physician's experience with the language and culture of minority, working class populations: Unfortunately, interviewing, as a diagnostic and therapeutic skill, is ignored and underestimated by many medical faculties. Departments of medicine often reduce interviewing to history taking. Although some emphasis is placed on past, family, and social history, the focus is directed toward disease specificity rather than the illness and its relationship to the patient, his family and his community.[28] Kimball observes that one way to enlarge the medical students' experience with the dialects of the working class community is to expose them to such groups during their training.

One medical school in the Southwest has planned a training session in clinical medicine in a neighborhood health clinic, learning interviewing techniques in the real world. In this case, the program requires that the medical students learn Spanish since most families enrolled in the neighborhood health clinic speak only that language. Obviously not much information is communicated unless the doctor learns to understand the patient in his own tongue. Not satisfied with this, Kimball suggests further: "In many of our urban medical schools physicians-in-training could use special courses in the culture and language of subgroups, whether or not they speak English."[29]

Another suggestion to overcome this middle-class bias of medicine and psychotherapy might be to recruit more doctors from the working classes in order to reduce this mismatch of language and culture from patient to doctor. As hopeful as this might sound, past experience has shown that there is something in the acquisition of medical knowledge which seems to wipe out former ties and culture. Casual observation of many physicians who come from the working classes has revealed a relative lack of sympathy toward patients of working-class status. Apparently the same assimilative phenomenon is at work in medicine that already has been observed in school teachers. Perhaps you can't really go home again, as Thomas Wolfe once said.

In an earlier paper on the problems of inner-city patients in the medical interview, I concluded that the communication continuum from doctor to patient could be described as follows:[30]

Doctors talking only Doctor language	Doctors talking Doctor language but understanding Patient language	Doctors talking and understanding both Doctor and Patient Language	Patients talking and understanding both Patient and Doctor Language	Patients talking Patient Language but understanding Doctor Language	Patients talking only Patient Language
1	2	3	4	5	6

Major communication breakdown occurred at numbers 1 and 6, the extremes (monolingualism). More generally, our research has revealed that patients realize that they must do the adjusting to the doctor so they try their best to produce their most formal and best rendition of appropriate doctor language (number 4).

Minimally patients are required to understand doctor talk (number 5). That paper argued that more of the pressure should be placed on the health delivery team and less should be required of the patient who is, after all, at the disadvantage of culture, training, language, emotion and health. One would expect medical schools to become concerned about the rights of patients, even to the extent of learning to understand them.

Meanwhile patients must also learn to expect such considerations. This means that patients will need to speak out loudly and clearly for dignity, clarity and decision making in their own health treatment. This is a somewhat new challenge for a group of people which has been systematically and culturally induced to accept without question their treatment in the health delivery services. In order to fully participate in the rights outlined in this paper, it will be necessary for the system to change. How soon this will happen is dependent very largely on the patients themselves.

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